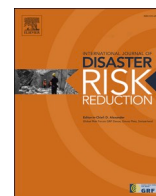




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Resisting the problematisation of fatness in COVID-19: In pursuit of health justice

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ABSTRACT

The purpose of this paper is to explore the problematisation of fatness in contemporary responses to the COVID-19 pandemic. This paper draws from the catalogue of reports from journalists informed largely by an array of non-peer reviewed scientific literature documenting the relationship between fatness and COVID-19. Our method of enquiry is to examine fatness and COVID-19 through a problematisation lens that enables us to interrogate the scientific, political, and economic processes implicated in the production of fat bodies as problems. Fatness has been problematised in the COVID-19 pandemic. This has diverted responsibility for preparedness and well-being away from health systems and governments and onto the back of fat people and communities. This is unjust and unethical. In juxtaposition, fat activists around the world have challenged the problematisation of fatness and its effects, finding ways for fat people to subvert fat phobic institutions in the midst of the COVID-19 pandemic by collectively organising to support one another. The ways in which fatness is being taken up in current COVID-19 pandemic responses diverts responsibility for health system preparedness and community resiliency to fat individuals. This is both unjust and also obstructs meaningful action to address the health inequities laid bare by COVID-19. This paper is believed to be the first to analyse the problematisation of fatness in COVID-19, highlighting that lessons can be learned about health justice in disasters from the work of fat activists during this COVID-19 pandemic.

1. Introduction

As the world unites to address the global pandemic of COVID-19 (SARS-COV-2 novel coronavirus) questions of health equity and justice are at the fore. Clear patterns of vulnerability along axes of race, indigeneity, disability and socio-economic status, are evident amongst those most at risk of hospitalisation and death from the virus in Global North countries [e.g.1,2,3], and amongst those most immediately affected by the resulting social and economic shocks [e.g.4,5]. This underscores the importance of global efforts to address the social determinants health, those wider social, economic and political forces and systems that shape the conditions of people's daily lives and are mostly responsible for unfair and avoidable differences in health status within and between countries [6,7]. However, instead of a mobilisation of efforts to address health inequities we are witnessing a re-energisation of discourses of individual responsibility and blame for vulnerability to poor health that have characterised the health landscape in Global North countries in

recent decades [8,9]. This is particularly evident in the ways in which pandemic responses are pushing renewed energy into the moral panic around fatness, reinforcing the problematisation of fat people as subjects of blame for poor self-management and as burdens on healthcare resources and community wellbeing.

This paper presents a critical response to the scapegoating of fatness in contemporary responses to the COVID-19 pandemic. We begin by tracing the problematisation of fat bodies in Global North countries in recent decades through the emergence of a weight-centered health paradigm and the resulting efforts to tackle "obesity" [10,11]. We then explore the various ways in which pandemic responses have taken up and are amplifying this problematisation. We draw parallels between the treatment of fatness in the current COVID-19 pandemic and other disaster contexts. We argue that the problematisation of fatness in current COVID-19 pandemic responses is diverting responsibility for health system preparedness and community resiliency to fat individuals. This is both unjust and also obstructs meaningful action to address the health

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inequities laid bare by COVID-19. We conclude this article by profiling the efforts of the fat activist community to confront the problematisation of fatness in COVID-19 responses in order to provide fat people with opportunities to collectively organise and advocate for their own needs. We affirm these actions as a model for health justice in the face of a global pandemic.

We purposely use the term fat to signify fatness, the fat body, and fat people. Using fat, rather than the normative overweight or pathologising obesity, signals our commitment to avoid further stigmatising of fatness and fat people in this scholarship. It is also the preferred word to use in the work of Fat Studies scholars and fat activism [12,13].

2. The problematised fat body

The utility of the fat body as an object of blame and sanction in current responses to the COVID-19 pandemic piggybacks the problematisation of fatness in recent decades. Problematisations, as a method of enquiry, draws our attention to the political interests and power relations that constitute “problems” as accepted truths, and their harmful effects, in order that they might be challenged and reconstituted in more productive ways [14].

Through the problematisation lens, the “fact” of fatness as a marker of ill-health and poor self-management in Global North countries is revealed as a relatively recent and highly politicised phenomenon [10]. Fat bodies have been transformed into a major health problem framed as draining the health system of finite resources. The health system response has been a weight-based paradigm which contains a set of core assumptions about the fat body. The first assumption is that fatness is central to the health status of individuals, both as an underlying risk factor for chronic illnesses including type 2 diabetes, heart disease, stroke and some cancers, as well as a disease in its own right [6]. The second assumption is that fatness is primarily the result of an imbalance between energy in and energy usage and thus is mostly under the control of the individual through their choices related to diet and physical activity [15]. The third assumption is that weight loss is a realistic and achievable goal for most fat people, that can be achieved through changes in diet and physical activity, and will result in improved health [16]. The fourth assumption is that the current and future health status of the individual can be predicated based on body mass index (BMI) categories [10]. The resulting efforts to tackle “obesity” have dominated health and social policy in Global North countries for the past two decades.

The problematisation of fatness is subject to broad criticism. Critical scholarship from a variety of disciplines alongside fat activists question many of the core assumptions that underpin the weight-based paradigm and problematisation of fatness, noting contradictions and problems regarding obesity’s measurement, causes, and solutions [17]. The harmful effects on fat people resulting from the problematisation of their fatness as a health issue including legitimising and amplifying fat hatred, the impossibility of sustainable weight-loss for many fat people, and the possibilities for healthiness whilst fat have been comprehensively demonstrated in research both within and beyond the emerging interdisciplinary fields of fat and critical obesity studies [e.g. 11,16,18]. A key concern in critical scholarship has been the utility of ‘obesity’ in Global North countries to detract from state responsibility for, and involvement in, the conditions that determine the populations’ health and social welfare by responsibilising the individual with their own self-management [8,17,19,20]. This positions fat people as subjects of blame and sanction without regard to the extent to which fat people can access the resources they need to be self-managing citizens who achieve health through slenderness. This is particularly the case for fat people of colour and indigenous people, fat people who live in poverty, and fat people with disabilities who live with the compounded effects of racism, colonisation, socio-economic marginalisation, and ableism. Nowhere is this more starkly seen than when Governments fail to attend to the safety and security of fat people during times of disaster.

In the disaster space, preparedness is key and often centers around environmental events e.g. flood, earthquake, or fire [21]. Hospitals and clinical centers are required to plan for hazards and associated evacuation. Accounts of fat bodied people being left behind in flood and storm events following triaged evacuations [e.g. 22,23] serve to highlight to agencies the need to plan and prepare to include fat bodies in disaster risk reduction and yet Gray and MacDonald [24] noted that fat bodies were ‘conspicuously invisible’ from the disaster risk reduction literature.

In 2005, Hurricane Katrina unleashed a major storm across New Orleans and surrounding areas. Failing levees and subsequent flooding that bore down on New Orleans led to many deaths. In one medical facility Emmett Everett, at 172 kgs had specifically asked one nurse to make sure he was not left behind as people were evacuated around him. Other staff are reported to have decided that it would not be possible to evacuate him. This man died in Memorial Medical Center with drugs in his system that he was not previously known to be prescribed (morphine and midazolam) and that did not align with the fact that he fed himself breakfast earlier that day. It was alleged that he was deemed too heavy to be evacuated down the stairs and a doctor had administered such drugs to hasten his death [22].

Some years later Superstorm Sandy hit New York City in 2012. Bellevue Hospital Center was evacuated and forced to close for the first time in over 275 years. Two patients could not be evacuated from the 25 Storey facility with 800 inpatient beds. One patient was medically unstable and could not be moved. Another patient was left behind on the 15th floor because of her shape and weight. While evacuation drills had been conducted none had trialled the evacuation sled with representative size and shape. Safety concerns for her and staff and being deemed too wide for evacuation on the sled down the narrow stairway [23]. Such decisions serve to amplify the problematisation of fat. These patients were fat when admitted to the facility, and were unlikely to experience significant changes in body fatness before or during the storms and so we have to question why such considerations were not worked through on admission. In the health space, pandemics present another kind of disaster of concern to fat bodies.

3. The problematised fat body in COVID-19

The World Health Organization and the US Centers for Disease Control and Prevention list obesity as an “underlying medical condition” that increases the risk for severe illness from COVID-19 [6,25]. While multiple articles, viewpoints, and correspondence pieces have been published that argue for a strong relationship between obesity and COVID-19 [26–31], Flint and Tahrani [32] argued in *The Lancet* that “to date, no available data shows adverse COVID-19 outcomes specifically in people with a BMI of 40Kg/m² or higher” (para 3). They suggest it is this lack of data that has led to increased anxiety for fat people, as they have been classified as at higher risk for complications. This same lack of data, argues Flint and Tahrani, might lead non-fat people to have a false sense of safety. But other scholars believe that even without data, positioning obesity as a risk factor is important. Kassir [26], for example, begins their Editorial, “Even though there are very few available data on BMI for patients with COVID-19 infections, the role of obesity in the COVID-19 epidemic must not be ignored” (para 1).

As the clinical risk of fatness remains contested, it is worth noting the associations between body weight and risk are often confounded. For example, multiple studies reported higher risk and higher severity of H1N1 amongst fat people in 2009 [e.g. 33,34]. However a systematic review and meta-analysis of H1N1 and BMI shows that after adjustment for medical fat bias concerning early antiviral treatment and BMI there was no increased risk of death for fat people (BMI 25 and above) [35]. Higher BMI is more prevalent in ethnic minority populations and poorer populations, both of which need to be adjusted for in any analysis before reaching a conclusion regarding the role of BMI versus access to timely healthcare, structural stigma and discrimination.

Irrespective of actual risk, the association between fat bodies and

COVID-19 has been thrust into the spotlight. The most visible public health official in the United States, Dr. Anthony Fauci, has continually stated that fat people are at a higher risk for developing severe cases of COVID-19; many have taken this up as an indictment. A Reuters story about Louisiana's death rate argued that the death rate in that State was higher than others (such as New York's) because of fatness [36]. While it is true that a quarter of the people who had died (thus far) from COVID-19 in Louisiana were fat, that is representative of the quarter of the overall population of the state who are fat. Stories in other outlets, such as the *New York Times*, have also echoed that fat people (specifically fat men) are at higher risk to be hospitalised and/or die after contracting COVID-19 [37]. In addition, many individuals with social media platforms have used this COVID-19 pandemic as an opportunity to entrench their anti-fat attitudes and calls for the elimination of fat people. Ahmed [38], for example, published a piece entitled, "The coronavirus shows why we have to tackle the obesity crisis". As government, public health officials, and journalists problematise fatness, it is heard by everyone including healthcare providers who will be assessing whether their fat patients will receive testing and treatment for COVID-19.

A case in point was the treatment of Lauren Rowello whose provider was resistant to prescribing an additional course of steroids to treat her pneumonia/possible case of COVID-19. The reason for this reluctance was, "that medication could lead to weight gain" [39]. Lauren asked more than once, sharing that her symptoms had greatly improved while on the course of steroids prescribed by another provider a week or so earlier. The provider, however, did not change her mind. In sharing her story, Lauren noted that her weight was not included in the medical history provided, nor was something gathered in the vitals information by the telemedicine. The provider may have deduced from seeing Lauren's face on screen that she was fat, or perhaps the provider simply thought weight gain was too big of a risk for anyone, regardless of size, to treat the condition. Lauren reflects, "In that moment, she projected a cultural ideal onto my treatment – encouraging the belief that it would be better to maintain my size than conquer life-threatening pneumonia" [39, para 17]. Luckily for Lauren, she was able to find another provider who listened to her symptoms, her needs, and was able to prescribe the appropriate medication to treat her illness. Unfortunately, it is very likely that many fat people around the world suffering from COVID-19 will not be this lucky.

As the fat body becomes problematised in COVID-19, governments are pushing renewed energy into efforts to tackle "obesity." Prior to COVID-19 the momentum had dissipated after twenty years of dominating health and social discourse. This was arguably due to a complex interplay of factors including growing evidence of the ineffectiveness of state-led weight-loss interventions aimed at individual behaviour change [40,41] and inroads made by critical discourses into the weight-centric paradigm [11,15]. Certainly in Aotearoa New Zealand in the months before we would hear of COVID-19 for the first time, obesity prevalence and prevention had shifted from being a constant feature of news media headlines and a leading policy objective as it was in the early-mid 2000s to a lower-level and more diffuse priority approached with a greater sense of political caution [42–44].

COVID-19 has upended this progress. Governments on the defensive about the lack of pandemic preparedness and responding to the patterns of health disparity illuminated by COVID-19, have been quick to mobilise fatness as an underlying driver for vulnerability to COVID-19 and as an avoidable strain on health systems responding to the COVID-19 pandemic [45]. Obesity in the context of COVID-19 is once again front page news [46] and government measures aimed at population obesity reduction and prevention are finding new footing [47]. As a result many of the core assumptions of the weight-based paradigm are being reproduced despite now ample evidence that they are ill-founded [48]. These assumptions are starkly reflected in policy initiatives being proposed to tackle obesity in the context of COVID-19 that target individual's food choices and physical activity [47], along with proposals to reboot public funding for bariatric surgery programmes [49–51].

For example, at a time when the UK is struggling to contain COVID-19 and ministerial ineptitude, promoting weight loss benefits of risk reduction including COVID-19 where there is no proven risk reduction link [52] is disingenuous. Spearheaded by the UK prime minister who himself was hospitalised for COVID-19 and self reports as fat, heralding his recent 6 kg weight loss, promoting that fat Britons will be prescribed bike rides by doctors [53]. The scapegoating of fat bodies within Government responses of COVID-19 is not just expressed in policies aimed at obesity prevention, but also in proposals to ration COVID-19 care and resources away from fat people.

The concern of health services being overwhelmed by an influx of patients with COVID-19 has become reality. Public health officials and governments grappled with modelling reports to predict and plan for 'worst case scenarios' regarding possible infection reproduction rates [54]. Proposals to ration care, specifically access to respirators and ventilators were ruminating between bioethicists and doctors [55]. The reality of critical care services being unable to cope and the very real possibility of rationing came to the fore, focusing people's fears [56,57]. This resulted in proposed rationing plans that excluded people from care, such as the elderly, those with disabilities, and those that are fat [58].

For example, the State of California's original Pandemic Care Guidelines suggested rationing decisions should be made that considered the age, pre-existing conditions, and ability level of the patient. Following widespread outrage, the State of California revised its guidelines in June 2020, directing that decisions about healthcare and resource allocation must not be based on weight or weight related conditions and many other denominators such as age, gender, ethnicity, and disability [59]. Ultimately, triage and resource decisions often sit with the attending medical team and such decisions are open to discrimination and bias [57].

Fat people diagnosed with COVID-19 are not the only fat people at risk; fat essential workers are as well. The shortage of personal protective equipment (PPE) for frontline health (and other essential workers) during this COVID-19 pandemic has been a worldwide problem [60–64]. In the United States, healthcare workers in hospitals serving communities of colour and those in rural hospitals and nursing homes have been most hard hit due to their employer's lack of resources [65]. Workers are being made to make their own personal protective equipment, inappropriately reuse PPE, or simply go without. Those who are able to source the necessary PPE often find that it is not suitable due to a one-size-fits-all manufacturing [66,67]. In addition, that one-size-fits-all is not modelled after a woman's body, or a disabled body, or a fat body; it has been designed for a male body [68]. A report from the Trades Union Congress [69] found that only three in ten women in the UK have PPE that fits them appropriately. Women healthcare workers in the UK have taken to social media to show off pictures of themselves in their ill-fitting PPE [67]. In normal times, poor fitting PPE makes it more difficult for individuals to complete their tasks and puts them at risk for accidents and injury [70]. But during the COVID-19 pandemic, it puts individuals at risk for becoming unwell. For fat people especially, the lack of appropriately fitting PPE is problematic; fat people may have difficulty fitting into gloves, eye protection, safety clothing, and more [71].

4. Confronting the problematisation: fat activism responses

Fat activists around the world have been quick to challenge the problematisation of fatness in the COVID-19 pandemic and to reveal its harmful effects on fat people. These responses have included published pieces that illuminate fatphobia within the COVID-19 pandemic; illustrating how fatness is positioned as a high risk and high burden for health resources, while also being positioned as an impending consequence for non-fat people spending time in quarantine (oh no! The quarantine 15!) [72–76]. Da'Shaun Harrison [77] illustrates how the positioning of fatness during COVID-19 fits into the larger eugenicist

history of the Centers for Disease Control in the United States. Danish fat activist Dina Amlund [78] has highlighted the discrimination faced by fat people in employment settings, making it more likely that they are less financially secure than non-fat people during this time of economic recession. This same discrimination occurs in healthcare settings, as noted by Amlund, with fat people being positioned as both higher risk of illness and less likely to recover. Amlund concludes, “I hope that fat people everywhere will get equal treatment during this pandemic. And I hope that fat people everywhere will not have to suffer harder than everyone else during the financial crisis upon us” [78, para 25]. Fat ally Christy Harrison [79], of the Food Psych Podcast, published a piece in *Wired* that reviews the evidence around fatness and COVID-19. Fat activists have also organised campaigns to bring attention to these concerns and fight for appropriate care for fat bodies; this includes Yes2Bodies in Switzerland [80], the Fat Rose in the United States, and the German Society Against Weight Discrimination in Germany.

Fat activists, Fat Rose, have led the #NoBodyIsDisposable (#NBID) campaign against discrimination in triage [81]. This campaign is composed of groups often targeted by care rationing plans, such as those with disabilities, fat people, old people, and people with HIV/AIDS (and other chronic illnesses) to fight back against triage plans that would sacrifice them for the well-being of others. The #NBID campaign partnered with civil rights organisations and medical professionals to raise awareness about triage and rationing plans and fight against them. The campaign invited everyone to take three actions. These actions included signing an open letter to healthcare providers, contacting government officials, and share a solidarity selfie [81].

Around the campaign, the #NBID campaign built a website of resources for individuals who may be at risk for triage discrimination. The website hosts information on important documents to prepare before you become ill, and what to bring to the hospital. Included in the latter is the “Connection Kit”. This “Connection Kit” contains items like contact info for family and friends, a “humanising photo of yourself in your normal life with friends or at work” [82], and a mini summary about the individual going into hospital. They suggest putting these items into a clear plastic bag or plastic protector, with a string through it that can be tied to a gurney or looped around the individual’s wrist. Additional material is provided on where fatness is afforded equal protection under the law across the United States (such as the city of San Francisco or the State of Michigan), and strategies that can be used to advocate in a hospital setting. Support resources have been developed by others. For example, “How to Survive COVID-19 Service Rationing” [83] is a U.K. document that acknowledges the vulnerability of fat and disabled people to rationing decisions and encourages everyone who can to make a plan now and discuss it with the people close to them. They also recommend completing a power of attorney online, if this is a feasible option.

Across the Channel, We4FatRights have developed resources to support activists who wish to push back against rationing plans from institutions and EU member states. This group began as a project of Yes2Bodies and the German Society against Weight Discrimination. In their goals, they state, “We strictly reject state-prescribed flow charts that decide over life and death based on visual diagnosis, age, disability, and ethnicity” [84]. The goals are available in a range of European languages, including German, English, Dutch, Icelandic, Swedish, and Spanish. The resources include social media appropriate protest images and an open letter that individuals and organisations may sign. They note, “The serious moral decisions the medical professionals are confronted with have arisen from various economic decisions in recent years. They do not reflect the existing capital within the European countries that could be available for adequate medical care” [85]. The letter draws on a 2020 decision from the German Ethics Committee that proposed that States may not ethically dictate triage situations to medical professionals [86], as cited in We4FatRights [85]. The letter concludes by demanding that institutions make a clear position of their equal treatment of fat people (both during COVID-19 and in general

care), and a call for questions of care during the COVID-19 pandemic, and especially ones related to triaging, to be addressed in trans-disciplinary ways with inclusion by individuals most vulnerable.

5. Moving beyond problematisation: A model for radical health justice

The global impacts of COVID-19 will be felt by many for generations. The Sendai Framework for Disaster Risk Reduction [87] recommends greater focus on evidence-based reviews of risk assessments, and to better understand behaviour and decision making relating to vulnerable groups for the health and emergency sector [88]. On the one hand it would seem highlighting the apparent vulnerability of fat people to COVID-19 should be helpful, however in making connections which may prove more tenuous than actual, lays bare the problematisation of fat and will increase vulnerability in particular in relation to stigma, bias, and discrimination.

As we have demonstrated, questions remain about the quantitative risk of the association between fatness and COVID-19. Regardless of the lack of conclusions we can draw about the risks, the fact remains that the weight centered paradigm has not reduced fatness or improved the health of fat people. COVID-19 illuminates and highlights the deep seated inequities already in existence that are independent of weight, but rather caused by the underlying drivers of social determinants of health such as poverty, racism, and other forms of structural oppression. In addition, the lifespan experience of fat stigma and oppression that fat people face increases fat people’s vulnerability to the negative impacts of the COVID-19 pandemic. In this light, we must reject the use of fatness, framed as individual responsibility, to distract from government responsibility for pandemic preparedness, response, and management. We must insist on the inclusion of appropriate PPE for fat workers, and strongly reject any plans or triaging that exclude fat people from necessary and appropriate COVID-19 care. COVID-19 underscores the importance of global mobilisation to address structural disparities that drive health inequities, so powerfully highlighted by this COVID-19 pandemic.

Fat activists are the experts of their own communities and have a strong tradition of challenging scientific “facts” about fat bodies, finding ways to subvert fat phobic institutions, and providing fat people with the means to advocate for their own needs [89]. These actions are well aligned with the Sendai Framework for Disaster Risk Reduction [87] which needs better understanding of risk “in all its dimensions of vulnerability, capacity and exposure” (p.14). These align with the United Nations System to leave no one behind through a lens of non-discrimination” [90] The mandate to leave no one behind during disasters recognises the fundamental principle of human dignity. In the face of this global pandemic this means ensuring that all people, regardless of their size, have the resources they need to navigate COVID-19 and to access equitable health care. Lessons should be learned from the work of fat activists during this COVID-19 pandemic, who have critiqued the association between fatness and COVID-19 risk, named fat phobia in pandemic responses, and quickly organised to identify their community priorities, resources, and plans for action. They loudly repudiated the renewed energy COVID-19 brought to the problematisation of fatness and rejected plans that would deny fat people care, and prioritised the needs of their most vulnerable members. The actions of fat activists to confront and challenge the problematisation of fatness in COVID-19 and its effects should be seen and valued as a model for health justice in disaster responses.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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